Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
**Fax: 206-418-5515**

# Legionellosis

**County**

**LHJ Use** **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
**LHJ Classification** ☐ **Confirmed** ☐ **Probable**
**By:** ☐ **Lab** ☐ **Clinical** ☐ **Other:** _____
**Outbreak # (LHJ)** _____ **(DOH)** _____

***DOH Use*** ***ID*** _____
***Date Received*** ___/___/___
***DOH Classification***
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

## REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

## PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

## CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

### Signs and Symptoms

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | **Fever** Highest measured temp ($^{o}$F): _____ ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk |
| ☐ | ☐ | ☐ | ☐ | **Cough** Onset date: ___/___/___ |
| ☐ | ☐ | ☐ | ☐ | Nonproductive cough |
| ☐ | ☐ | ☐ | ☐ | **Muscle aches or pain (myalgia)** |

### Predisposing Conditions

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Chronic liver disease |
| ☐ | ☐ | ☐ | ☐ | Immunosuppressive therapy or disease |
| ☐ | ☐ | ☐ | ☐ | Chronic diabetes |
| ☐ | ☐ | ☐ | ☐ | Chronic lung disease |
| ☐ | ☐ | ☐ | ☐ | Smokes tobacco |

### Clinical Findings

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | **Pneumonia or pneumonitis** X-ray confirmed: ☐**Y** ☐**N** ☐**DK** ☐**NA** |
| ☐ | ☐ | ☐ | ☐ | Pontiac fever |
| ☐ | ☐ | ☐ | ☐ | Admitted to intensive care unit |
| ☐ | ☐ | ☐ | ☐ | Mechanical ventilation or intubation required during hospitalization |

### Hospitalization

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Hospitalized for this illness |

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Died from illness Death date ___/___/___ |
| ☐ | ☐ | ☐ | ☐ | Autopsy Place of death _____ |

### Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___

| P | N | I | O | NT | |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | **Legionella culture (from normally sterile site—lung tissue, pleural fluid, respiratory secretions, other fluid)** Species: _____ |
| ☐ | ☐ | ☐ | ☐ | ☐ | ***L. pneumophila* serogroup 1 antigen detection in urine using validated reagents** |
| ☐ | ☐ | ☐ | ☐ | ☐ | ***L. pneumophila* serogroup 1 specific serum antibody titer with ≥ 4-fold rise using validated reagents (acute and convalescent serum pair)** |
| ☐ | ☐ | ☐ | ☐ | ☐ | Titer to Legionella species/serogroups other than *L. pneumophila* serogroup 1, ≥ 4-fold rise [*Suspect]* |
| ☐ | ☐ | ☐ | ☐ | ☐ | *L. pneumophila* antibody titer to multiple species (pooled antigen) with ≥ 4-fold rise *[Suspect]* |
| ☐ | ☐ | ☐ | ☐ | ☐ | Legionella antigen or organism detected by DFA, immunohistochemistry, or other method *[Suspect]* |
| ☐ | ☐ | ☐ | ☐ | ☐ | Legionella species detected by validated nucleic acid assay *[Suspect]* |

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

## INFECTION TIMELINE

***Enter onset date (first sx) in heavy box. Count backward to figure probable exposure period***

| | ***Exposure period*** | | onset |
|---|---|---|---|
| *Days from onset:* | -10 | -2 | |
| *Calendar dates:* | | | |

## EXPOSURE (Refer to dates above)

**Y N DK NA**

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____

☐ ☐ ☐ ☐ Travel associated: spent at least one night away from home in the ten days before onset of illness (includes same country of residence or abroad)

☐ ☐ ☐ ☐ Patient hospitalized >48 hours before illness onset
# days before onset: _____

☐ ☐ ☐ ☐ Work or volunteer in health care setting during exposure period
Facility name: _____

**Y N DK NA**

☐ ☐ ☐ ☐ Visited health care setting during exposure period
Facility name: _____
Number of visits: _____
Dates of visits: _____

☐ ☐ ☐ ☐ Travel or overnight stay other than residence
Specify where: _____

☐ ☐ ☐ ☐ Aerosolized water (e.g. fountains, spas, humidifier, hot tub)

☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)

☐ ☐ ☐ ☐ Soil exposure (e.g. gardening, potting soil, construction

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

**Most likely exposure/site:** _____ **Site name/address:** _____

**Where did exposure probably occur?** ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

## PATIENT PROPHYLAXIS/TREATMENT

## PUBLIC HEALTH ISSUES

**Y N DK NA**

☐ ☐ ☐ ☐ Nosocomial infection suspected

☐ ☐ ☐ ☐ Visited health care setting during exposure period
Facility name: _____
Number of visits: _____
Date(s) of visit(s): _____

☐ ☐ ☐ ☐ Outbreak related

## PUBLIC HEALTH ACTIONS

☐ Facility notified
☐ Facility inspection

## NOTES

**Investigator** _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

**Local health jurisdiction** _____ **Record complete date** ___/___/___

Legionellosis: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered